7 Steps to Health Market Analysis

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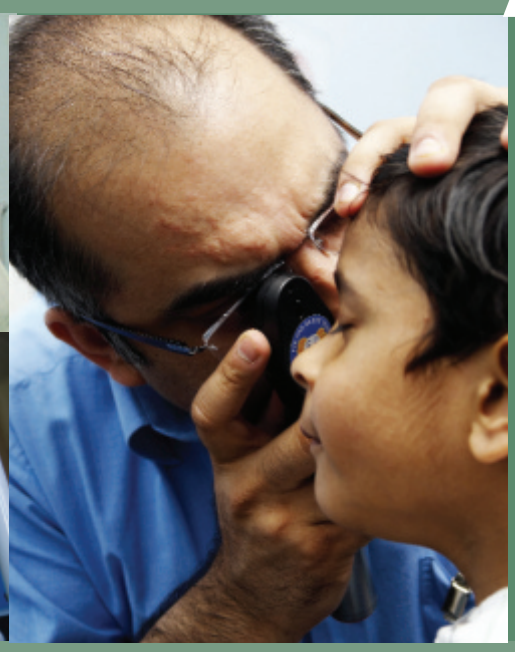

MAKING HEALTH MARKET ANALYSIS WORK FOR YOUR PCT

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NHS North West

About health economics in the North West

NHS North West was the first SHA to appoint a Chief Economist, Kirsten Major. Since joining the SHA, Kirsten has employed her wealth of NHS experience to promote the use of economics in decision-making throughout the region. Earlier this year, Kirsten was joined by Darrin Baines to help build the health economics capacity within the SHA.

Kirsten and Darrin are currently involved in a range of work designed to support the local health economy. Apart from Health Market Analysis, their recent projects include:

- Advising PCTs on competition and cooperation issues
- Analysis of Programme Budgeting data to help PCT decision-making
- Assisting the region shape its response to the economic downturn
- Supporting the delivery of the Transforming Community Services programme

Health economics is rapidly evolving in the North West. If you would like to talk to Kirsten about the use of economics within the NHS, please email her at: kirsten.major@northwest.nhs.uk

This guide is part of an on-going programme of work performed, for the benefit of local PCTs, by the economics team within NHS North West. With the launch of the latest World Class Commissioning competencies and the financial consequences of the economic downturn, economic input into NHS decision-making is becoming more important to securing better value for money in patient services. Health Market Analysis is an economic tool that can produce direct benefits in terms of quality and efficiency gains.

Welcome to HMA

Health Market Analysis (HMA) is an important new tool for analysing whether the quality and the cost-effectiveness of NHS services may be improved by using market levers such as contract management, competition and tendering. This document outlines a Seven Step framework for HMA developed by the economics team within NHS North West for use by PCTs within the region.

These 7 steps have been designed to help your PCT successfully assess local health markets. The key emphasis is on driving quality and improving value for money. We also show how health market analysis can help deliver World Class Commissioning (WCC) competencies. Our framework is based upon good practice in other industries, lessons learnt from HMA pilots (both nationally and in other SHAs) and recent experience within the region with Transforming Community Services.

When using this guide or any other approach, it is incredibly important not to be seduced by the analysis itself. HMA can only ever provide information, evidence and suggestions for the strategic approach adopted by PCTs. Such analysis cannot, by itself, deliver the answers. At best, HMA will improve the quality and transparency of PCT decision-making around their ambitions for the health and health care for local people. HMA should always be seen as the means not the ends: the beginning of the journey not the destination.

Kirsten Major
Chief Economist, NHS North West

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These 7 steps have been designed to help your PCT successfully assess local health markets. The key emphasis is on driving quality and improving value for money. We also show how health market analysis can help deliver World Class Commissioning competencies.

How to use this guide

Under the latest WCC Competencies, all PCTs must stimulate local health markets and have in place a range of responsive providers that they and their populations can choose from. PCTs must not only shape existing provision, but they must have developed clear strategies to address inadequate provider choice, especially in areas of relatively poor quality or efficiency. A robust approach to HMA is critical to being able to deliver these objectives. To promote joined-up commissioning and planning, your PCT should undertake this HMA in collaboration with your Local Authority, which will also help meet WCC Competency Seven.

The approach to NHS market analysis developed is based upon Michael Porter's "The Five Competitive Forces That Shape Competition". The approach was chosen because of its ability to analyse the factors that promote "healthy" markets in all sectors of the economy, including health. We have also incorporated learning from the pilot HMA work undertaken in other SHAs and nationally, as well as recent experience in the North West of conducting market analysis as part of Transforming Community Services.

To promote the use of HMA in practice, this document is accompanied by a collection of linked spreadsheets that you may use to record and analyse your collected data. The tables presented in this document directly link to the tables presented in the spreadsheets, using the same numbering system. This approach has been piloted with local PCTs (for which we are extremely grateful) and the lessons learnt have been incorporated into this first version of the framework.

Soon, the Department of Health will be launching a national HMA tool. Our guide has been developed as an accompaniment to the national framework. It is our view that this guide and the national tool complements each another. For instance, both approaches use Programme Bugeting data for analysis. The national tool also contains a wealth of data that PCTs can use to complete the Seven steps. Finally, the national tool is designed to help PCTs decide what kinds of market stimulation (if any) are appropriate for particular services. This information will be extremely useful in completing the HMA process outlined here.

This is the first edition of this guide to HMA in the North West. We would really welcome feedback about what is and is not useful to include in future versions. We will be updating the guide (and the linked spreadsheets) in the next twelve months to incorporate changes related to your comments and the launch of the national HMA tool. If you wish to be notified of these changes, please email Darrin Baines at economics@northwest.nhs.uk.

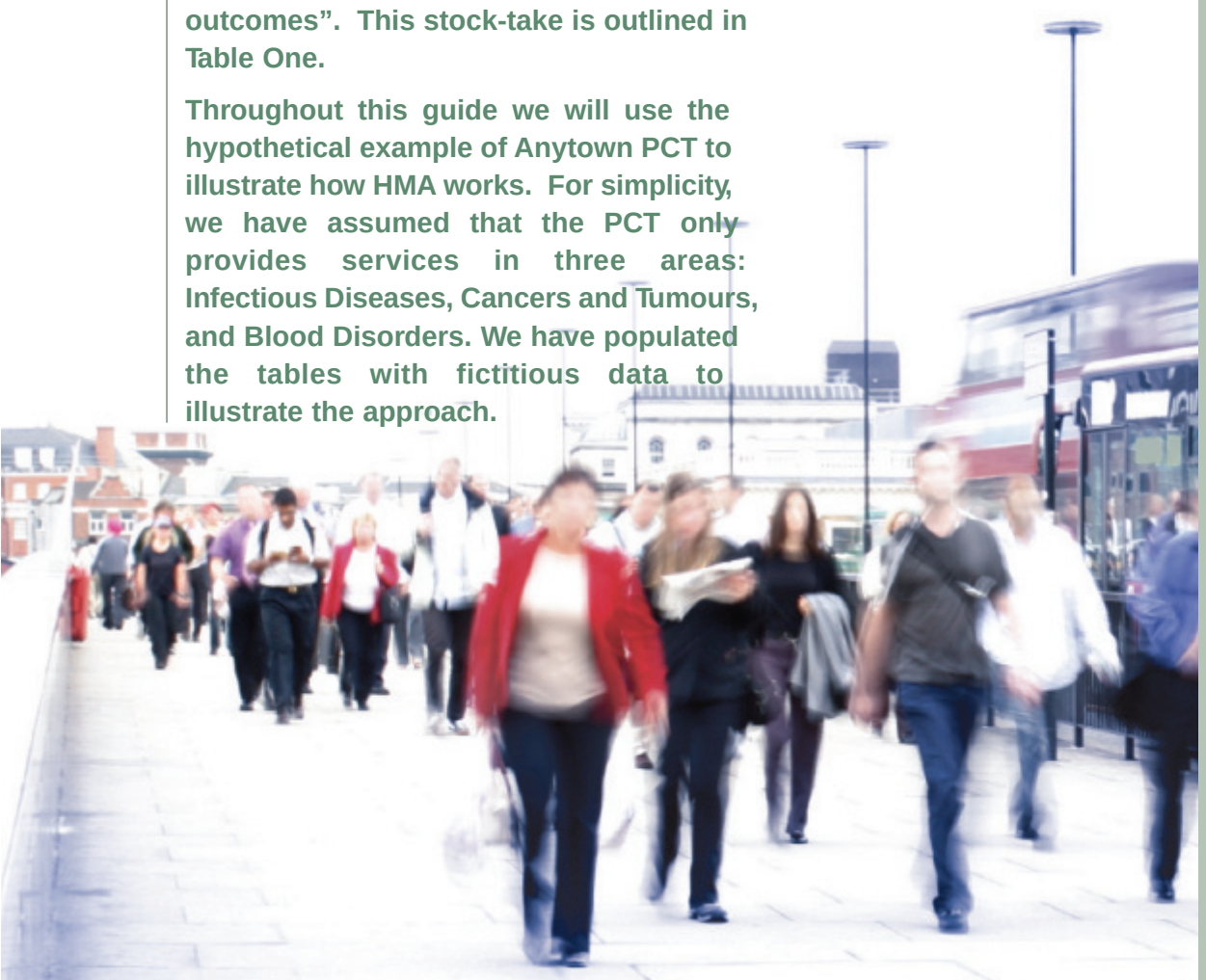
This guide outlines seven consecutive steps to successful HMA. They are set out in numerical order with instructions. All of the tables in this document link directly to the spreadsheets distributed electronically alongside this guide. If you would like further copies of this guide or the associated spreadsheets, please contact Darrin Baines at: economics@northwest.nhs.uk.

Seven steps to HMA

1. Provider quality and efficiency
2. Clinical priorities and opportunities
3. Defining markets for local population
4. Analysing local market structures
5. Identifying barriers to entry
6. Pulling your information together
7. Stimulating healthy markets

This guide has been specifically designed to help your PCT be World Class Commissioners. We have undertaken a stock-take of the details of the sub-competencies of WCC Competency Seven, "Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes". This stock-take is outlined in Table One.

Throughout this guide we will use the hypothetical example of Anytown PCT to illustrate how HMA works. For simplicity, we have assumed that the PCT only provides services in three areas: Infectious Diseases, Cancers and Tumours, and Blood Disorders. We have populated the tables with fictitious data to illustrate the approach.



PCT example, part one

Welcome to Anytown

Anytown PCT is located in a mixed demographic area. The population has a large proportion of older people, but with a large number of young, deprived and drug or alcohol dependent residents. There is one local acute provider that also provides services to three other PCTs, which fall within its catchment area. The trust has made significant quality improvements in recent years, but is struggling to deliver in some areas. The PCT hopes HMA can be a tool for assessing whether alternative means of provision can help stimulate quality and efficiency gains where deficiencies currently exist.

> Health Market Analysis can help deliver important parts of World Class Commissioning Competency Seven

World Class Commissioning

The Department of Health's World Class Commissioning Competency Seven requires PCTs to stimulate local health markets and to have in place a range of responsive providers that they can choose from. Not only must PCTs shape existing provision, but they must also have clear strategies to address any inadequacies in choice of providers. Competency Seven was the weakest area of PCT performance in the first year of WCC assurance. As Table One illustrates, following this HMA guide will help rectify this situation. However, no single piece of analysis or approach can deliver all of Competency Seven, so we have highlighted where HMA will need to be consolidated by PCTs.

Please note, Table One contains the most recent and available details relating to Competency Seven. There are likely to be some minor changes to wording following the Department of Health launch on 16 September 2009 of the updated WCC competencies and assurance process. These were not available prior to going to print with this document. Readers should check the most up to date version of WCC Competency Seven.

Table One. WCC Sub-competencies and HMA

WCC COMPETENCY	MEANS OF ACHIEVING THE COMPETENCIES	HOW THIS HMA GUIDE HELPS
7a. Knowledge of current and future provider capacity and capability	**YEAR ONE** • The PCT has analysed the market with the local authority and identified a full range of core providers for each speciality and level of care, including NHS providers, independent and third sector providers.	**YEAR ONE** This HMA should have local authority input, and including all disease areas and listed providers.
	• The PCT has conducted analysis to assess the relative costs and quality of providers to ensure services in place meet the needs of users.	Table Two records quality and efficiency in all providers.
	• The PCT uses patient feedback to gain a richer understanding of commissioned services.	Table Two uses patient satisfaction data.
	• The PCT has a complete and prioritised list of providers in the region and the scope of services provided by each. This list should include NHS, independent sector providers and PCT or GP organised diagnostic and treatment centres, third sector and social enterprise groups.	Table Three lists HMA priorities by PCT commissioning priorities and clinical areas for all providers.
	• The PCT has identified cost and quality for each procedure in each area of care and in each setting of care. • The PCT has developed a clear specification for each setting of care (primary, community, mental health) including quality, access and cost. • The PCT has dedicated resource containing expertise and experience to support provider capability development. • The PCT can demonstrate that it has established strategic relationships with providers that include the expertise and experience to support provider capability development.	These tasks are outside the scope of this HMA Guide. However, the SHA contracting team and the collaborative commissioning and procurement organisations in the region provide support and expertise in these areas.
	YEAR TWO • The PCT works with the Local Authority, other local PCTs and commissioners to: – Perform a robust market analysis on all segments of the market. – Identify a full range of core (current and future) providers (including NHS providers, independent and third sector providers) by speciality, pathway and setting of care.	**YEAR TWO** Your PCT should continue to work with your local authority to complete the seven steps of this HMA guide, which provides an analysis of your markets and identifies your providers.
	– Assess the relative cost, quality and patient feedback of providers and the services they deliver.	Tables Two and Three identify costs, quality and satisfaction of all local providers.

WCC COMPETENCY	MEANS OF ACHIEVING THE COMPETENCIES	HOW THIS HMA GUIDE HELPS
7a. Knowledge of current and future provider capacity	**YEAR TWO continued** • The PCT works with the Local Authority, other local PCTs and commissioners to: – Prioritise market segments for targeted improvement action. – Identify potential costs and benefits of changing or managing providers in priority segments.	**YEAR TWO continued** Table Eleven lists priority markets for change. Your PCT should identify the costs and benefits of switching providers.
	• The PCT has identified cost and quality for each procedure in each area of care and in each setting of care (where this information is incomplete, the PCT collects robust local data).	Identifying costs and quality at a procedure level is beyond the scope of this HMA, but PCTs should be using Advancing Quality, CQUIN, PROMs data and the performance management and monitoring of contracts to deliver this over time.
	• The PCT has developed a clear specification for each setting of care (acute, primary, community, mental health care) including quality, access & costs which reflects national and international best practice.	Your PCT should work with other PCTs and collaborative commissioning and procurement organisations to develop these specifications.
	• The PCT has dedicated resource and the necessary strategic partnerships with the right expertise and experience to support: – Robust market analysis. – Market management. – Provider capability development.	This HMA guide provides the basis for PCT to consider the expertise, experience and resources they need to undertake these activities.
7b. Alignment of provider capacity with health needs	**YEAR ONE** • The PCT uses demand projections, demand management assumptions and population need to project required capacity by speciality and matches this with provider capacity and adjusts spending accordingly (decommissioning as appropriate).	**YEAR ONE** Table Nine uses forecast spending over the next five years which should be based on robust projections, for example through work by the North West Intelligence Consortium.
	• The PCT has identified gaps in market supply and for risks in supply structure has mitigation plans.	Table Twelve identifies gaps in markets.
	• The PCT indicates specific changes to provider capacity and addresses gaps in provision.	The conclusion of HMA is to devise specific changes and approaches to delivering these that will address gaps.
	• The PCT models demand and supply scenarios that can be varied and tested with risk assessment.	Your PCT should be working with the North West Intelligence Consortium to develop these scenarios and building upon the predictive modelling work going on across the region.
	• The PCT is forecasting potential as well as current risks and has adequate mitigation plans, particularly where the impact is broader than the PCT.	Market based risks should be part of your PCT's risk management approach.
	• The PCT takes demand projections and incorporates demand management assumptions from strategic plan (e.g. pathway redesign) to identify required capacity by provider type, by speciality and by care/patient pathway. • The PCT implements specific changes to provider capacity driven by needs modelling, including long-term structural changes and forecasts based on actual risk analysis.	PCT demand projections can be linked to the spending projections in Table Nine. This shows which providers will experience increases or decreases in PCT revenues.
	YEAR TWO • The PCT uses demand projections, demand management assumptions and population need to project required capacity by speciality and matches this with provider capacity and adjusts commissioning and decommissioning accordingly.	**YEAR TWO** Table Nine identifies future spending patterns by provider, which may be linked to demand projections, management and need.
	• The PCT has identified gaps in market supply and for risks in supply structure has mitigation plans. • The PCT can demonstrate it understands different forms of market management. • The PCT identifies specific changes to provider capacity to optimize provision to address health needs. • The PCT models demand and supply scenarios that can be varied and tested with risk assessment. • The PCT is forecasting potential as well as current risks and has adequate mitigation plans, particularly where the impact is broader than the PCT. • The PCT identifies barriers to entry for providers and considers how to minimise the barriers. • The PCT has managed to deliver higher quality care at increased efficiency and effectiveness in its priority segments.	Table Twelve describes market health, whilst Table Thirteen outlines manageable aspects of the market, including barriers to entry. By addressing market health issues your PCT can promote better quality and higher levels of efficiency.

WCC COMPETENCY	MEANS OF ACHIEVING THE COMPETENCIES	HOW THIS HMA GUIDE HELPS
7b. Alignment of provider capacity with health needs projections	**YEAR TWO continued** • The PCT takes demand projections and incorporates demand management assumptions from strategic plan (e.g. pathway redesign) to identify required capacity by provider type, by speciality and by care/patient pathway. • The PCT implements specific changes to provider capacity driven by provider market analysis, needs modelling, including long-term structural changes, and forecasts based on actual risk analysis. • The PCT has successfully reduced or removed barriers to entry for new providers. • The PCT has managed the market to deliver higher quality care at increased efficiency and effectiveness across all service areas.	**YEAR TWO continued** Tables Eleven and Thirteen summarisesthe output of your HMA, and suggests how your markets should be restructured, including barriers to entry to be reduced or removed. This will help promote quality and efficiency improvements.
7c. Creation of effective choices for patients	**YEAR ONE** • The PCT regularly reviews the healthcare provision marketplace and identifies potential providers. • The PCT has a strategy for creating more choice when specific services lack credible alternatives. • The PCT involves patients in creating the choice offer, particularly those with long-term conditions.	**YEAR ONE** HMA reviews your existing providers and suggests how choice may be expanded by identifying alternative provision. Tables Eleven and Twelve identify how choice may be improved.
	• The PCT uses patient experience to develop specification of services and choices available.	PCTs should ensure this is incorporated into service specifications, although this is beyond the scope of HMA.
	• The PCT has clear investment and disinvestment processes.	The SHA health economics team has provided support in the past in this area and will do so again when the new WCC competencies are launched.
	• The PCT identifies the number of providers by disease area. • The PCT has clear investment and disinvestment processes which lead to a mix of providers based on clinically defined cost/quality trade-off.	Table Four identifies potential providers by disease area, which can inform PCT investment and disinvestment decisions.
	• The PCT explicitly tests the acceptability of the choice available with patients, on a regular basis. • The PCT has a coherent strategy for increasing personalisation of care including choice, addressing joint health and care needs.	These tasks are beyond the scope of HMA and should form part of your PCT's ongoing implementation of national policy with respect to choice.
	YEAR TWO • By provider, pathway and care setting, the PCT: – Regularly reviews the healthcare provision market place and the choice patients have. – Has a clear strategy, for creating more choice particularly when specific services lack alternatives. • The PCT offers patients choice of location, content, care setting, provider type, style of services and involving patients in creating the choice offer (particularly those with long-term conditions).	**YEAR TWO** HMA can inform your PCT commissioning strategy for creating greater choice.
	• The PCT: – Involves patients in creating the choice offer, particularly those with long-term conditions. – Makes information available to enable patients to exercise choice. • The PCT works with GPs and other referrers to develop an effective strategy to improve uptake of choice at a practice level.	These tasks are beyond the scope of HMA and should be part of your PCT's ongoing implementation of national policy with respect to choice.
	• The PCT uses its understanding of the market and patient feedback and input to make decisions on investment and disinvestment to create more effective choice. • The PCT has clear investment and disinvestment processes which lead to a mix of providers based on clinically defined cost/quality trade-off.	Tables Eleven to Thirteen may help your PCT make the necessary investment and disinvestment decisions.
	• The PCT explicitly and regularly: – Tests with patients the acceptability of the choice available. – Identifies and shares best practice for developing and communicating the choice offer. • The PCT has co-developed with Local Authorities a coherent strategy for increasing personalisation of care including choice, addressing joint health and care needs.	These tasks are beyond the scope of HMA and should be part of your PCT's ongoing implementation of national policy with respect to choice.

Step One. Provider quality and efficiency

In July 2009, leaders from the health economy in the North West attended an SHA-led summit to discuss the financial and economic challenges that will face the NHS in the region. Nationally, the framework for Quality, Innovation, Productivity and Prevention (QIPP) has been launched in response to the economic downturn. In keeping with the North West Summit and the QIPP framework, this guide places quality and efficiency at the heart of HMA.

The QIPP framework emphasises the importance of commissioning high quality, efficient services. In response, Diagram One has been designed as a "decision tool" to help your PCT determine which services may require alternative provision. On the vertical axis, the quality of provision is shown. On the horizontal axis, efficiency levels are given. In the bottom left quadrant, inefficient services of low quality definitely need a change of provider(s). At the other end of the spectrum, in the top right quadrant, efficient high quality services are acceptable. More equivocally, high quality but inefficient services should be explored as a possibility for provider change. Similarly, inefficient but low quality provision also needs to be explored. By following this decision tool your PCT may allocate its existing providers into the HMA categories of "Acceptable", "Change" and "Explore". These classifications will underpin your HMA. This process begins in Table Two (overleaf) which provides a means of analysing your quality, satisfaction and efficiency data.

Diagram One also represents levels of spending with existing providers in terms of circles containing coins. The bigger the circle the larger the spend, and vice versa. As good practice, we suggest that your PCT considers whether the biggest spending areas should be subject to alternative provision (even if they are efficient and high quality). For instance, changing providers for all or part of an existing spend may reduce expenditure, increase quality, or a combination of both. Therefore, considering alternative provision may be worthwhile.

Diagram One. How cost and quality criteria combine to inform alternative provider decisions

To help your PCT make the decisions of acceptable, change or explore shown in Diagram One, Table Two records the quality and efficiency of existing providers. We suggest that you use routinely collected quality data (such as Care Quality Commission annual health check data) and routinely collected productivity data (such as Better Care, Better Value indicators) to construct this table. However, data not routinely collected are also important and should be used whenever appropriate. For instance, we suggest using patient feedback data from local surveys. By combining routine and non-routine quality and efficiency data, Table Two suggests where market levers may be used to drive up quality and efficiency.

In order to help meet WCC sub-competency 7a, you should ensure that the data in Table Two cover all sectors of provision: NHS; independent sector; PCT or GP organised diagnostic and treatment centres; third sector; social enterprise groups.

Whilst Table Two reports the quality and performance of local providers, Table Three allows you to specify which clinical areas (which we measure using the 23 Programme Budget categories) should be prioritised by your PCT for consideration for the use of market levers and incentives, using the approach outlined in Diagram One. These data are useful for identifying specific clinical areas where there is lower quality in providers that, at an aggregate level, appear to be performing well.

Table Two. Quality, satisfaction and efficiency of providers

PROVIDER NAME	QUALITY MARKERS	PATIENT SURVEY DATA	EFFICIENCY MARKERS	ETC
Regional Acute Provider 1	High	85%	Good	....
PCT Provider Arm	Low	72%	Medium	
Local Acute Provider	Low	42%	Poor	
Regional Acute Provider 2	High	83%	Good	
....				
....				

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

By completing this table, your PCT can classify existing providers, in each of the Programme Budgeting categories, in terms of the Diagram One criteria of: (i) do not need to consider alternative provision at this stage (Acceptable), (ii) may require further exploration (Explore), and (iii) may need to use market levers and incentives (Change). By dividing providers into these categories, your PCT will meet the WCC sub-competency 7a requirement of prioritising all providers in the region.

PCT example, part two

By completing Table Two, Anytown PCT confirmed significant variations in quality and efficiency between local providers. This information confirmed the need to perform an analysis of local health markets in order to discover whether and where improvements in services are necessary.

Based upon Diagram One and Table Two, Table Three describes which clinical areas require change on quality and efficiency grounds. This information may be compared on a Provider-by-Provider basis, or by Programme Budgeting areas. However, these data require discussion to create Table Three. For instance, which level of quality is not acceptable and means that an alternative provider should be sought? Similarly, which levels of consumer satisfaction and efficiency suggest provider outcomes are acceptable? In the main, these thresholds depend upon PCT judgements and often cannot be decided purely by data analysis alone. Once you have divided your existing providers by clinical areas into one of the three groups, Table Three requires that you list potential entrants as "Explore" because they may become your providers of the future .

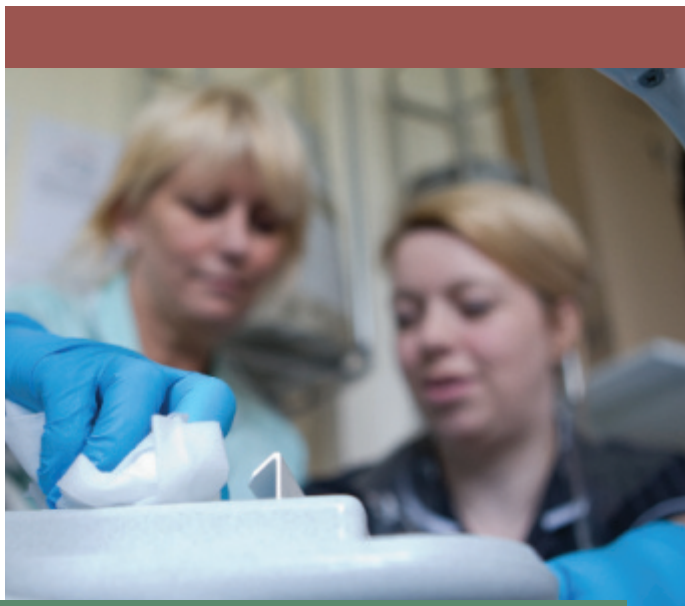


Table Three. HMA priority by provider and clinical areas

CLINICAL DESCRIPTION	EXISTING PROVIDERS					POTENTIAL ENTRANTS			
	PCT Provider Arm	Local Acute Provider	Regional Acute Provider 1	Regional Acute Provider 2	....	Third Sector Provider	Local Authority	..	..
Infectious Diseases	Change	Change	Acceptable	Acceptable		Explore	Explore		
Cancers & Tumours	Explore	Acceptable	Explore	Change					
Blood Disorders	Acceptable	Acceptable	Acceptable	Acceptable					
....									
....									

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

PCT example, part three

Anytown PCT used the data in Table Three to analyse the clinical areas within which providers failed to meet acceptable performance levels. The PCT Provider Arm and Local Acute Hospital both had unacceptable levels of quality and efficiency in the provision of services for infectious diseases. Similarly, Regional Acute Provider 2 failed to meet acceptable standards for cancer and tumours. In response, the PCT decide to use HMA as a tool for prioritising where and how services should be changed.

Step Two. Clinical priorities and opportunities

The next step is to identify spending by Programme Budgeting categories, broken down by existing and potential providers, which is recorded in Table Four. (If required, this approach may be used with clinical areas other than Programme Budgeting categories, such as pathways.) The table begins by collating existing PCT spending by Programme Budgeting categories. Next, the table requires that you list the total number of your existing providers. The table also lists potential entrants in each disease area. Please note, you may have a local provider currently involved in Cancer provision, but not involved in providing services for infectious diseases. If evidence suggests that this provider could successfully offer such services, then they may be classified as a "potential provider". Finally, the last column lists potential spends with potential entrants. This may be existing spending disinvesting from current providers, new monies, or a combination of both. The reason for collecting this figure is to indicate the relative size of spending with new incumbents. You are also likely to find analysis and benchmarking of your Programme Budgeting data useful here.

Table Four. Spending and quality by providers and Programme Budgeting categories

CLINICAL DESCRIPTION	EXISTING PROVISION (£)	CURRENT PROVIDERS (NO.)	POTENTIAL ENTRANTS (NO.)	POTENTIAL SPEND WITH NEW ENTRANTS(£)
Infectious Diseases	£4,722,000	14	10	£944,000
Cancers & Tumours	£23,508,000	15	7	£3,291,000
Blood Disorders	£5,413,000	10	1	£649,000
....				
....				

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

Table Five. Mapping of clinical and commissioning priorities

	HIGH COMMISSIONING PRIORITY	LOWER LEVEL OF COMMISSIONING PRIORITY
Change	Infectious Diseases	
	....	
Explore	Cancers & Tumours	
	....	
Acceptable		Blood Disorders
		....

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

Once you have entered data in Table Four, Table Five examines whether your choice for the HMA categories of "Change" "Explore" and "Acceptable" reflect your commissioning priorities. For instance, if your initial market analysis suggest that Infectious Diseases should be considered for change is the clinical area also a high commissioning priority? This table therefore is vital in ensuring that your HMA reflects your commissioning intentions.

Health markets and choice

Patient choice is an important element of WCC. Patients should be offered alternatives in terms of location, content and style of treatment. In response, PCTs should regularly test the acceptability of existing choices with patients, and use this information to develop a strategy of disinvestment and investment in order to improve user satisfaction. However, PCTs should be aware that not all services are suitable for choice. Consequently, you must decide whether choice is suitable for a particular service, and also what kind of choice (location, provider, treatment, etc.) should be promoted.

To help meet WCC sub-competency 7c, PCTs must identify existing and potential providers at a disease level, with the objective of assessing ways in which treatment options can be extended. In order to develop a clear strategy of creating more choice, each PCT must have a clear understanding of how local markets can help meet its aims. In response, Table Four responds to this challenge by identifying current and potential providers, based upon clinically defined cost and quality trade-offs (similar to those represented in Diagram One).

Your PCT may use Table Four to: (i) identify existing and potential providers, (ii) assess the relative quality and efficiency of these suppliers, and (iii) develop a local strategy for offering treatment alternatives in terms of location, content and style of treatment. By stimulating local markets in this way, patient choice will be improved, and WCC sub-competency 7c will be nearer to being delivered.

PCT example, part four

Quality in the area of infectious diseases had been of concern to Anytown PCT in the most recent year, with the result that the area became a high commissioning priority. In response, the PCT outlined a draft commissioning strategy, which was informed by the data on 10 potential new providers gathered during the HMA process. The estimated spend with this group was £944,000, funded by disinvesting spending from existing providers.

Step Three. Defining markets for local populations

By themselves, Programme Budgeting categories are not markets. They are clinical headings under which markets may be classified. For instance, there is not a market directly related to the Programme Budgeting category of “problems of hearing”; but there may be markets for “hearing aids” and “occupational hearing services”. In response, it is essential that your PCT should differentiate between “clinical areas” and “markets”.

Your PCT should define its markets in terms of the goods and services transacted and the locations involved. For example, your local market for hospice services may exist in a geographical area larger than your PCT, so using PCT boundaries may inappropriately restrict your HMA. Therefore, you should be careful when deciding the goods and services and locations that you believe define your markets. However, the optimum size for each of your local markets will depend upon the service in question and not just patient preferences.

Location, location, location

Currently, there is a growing debate over the optimal size of NHS markets in terms of locality, with arguments being made that patients do not wish to travel (for instance) more than 30 minutes to a provider. To help resolve this debate, it is worthwhile differentiating between the following:

1. Population being served (the locality where services are provided), and
2. Suppliers in the market (existing and potential providers).

For instance, a certain area within your PCT may have three local primary care practices, that supply anticoagulant monitoring services along with the local foundation trust. If these services are changed, suppliers in the market may no longer be locally based, but could be based several hundred miles away, using new technology to meet patient needs. However, a provider is not considered a potential market incumbent unless they can serve the needs of local patients. Therefore, your PCT should look for providers outside its boundaries as long as local needs are being met.

> By themselves, Programme Budgeting categories are not markets. They are clinical headings under which markets may be classified

Table Six is designed to record the location of existing and potential market providers. You will be asked to provide spending levels for both groups of providers in Table Seven (overleaf). PCT and regional boundaries have been chosen as starting blocks for analysis. However, if your PCT identifies alternative market boundaries, these may be used legitimately if s uch markets exist. For instance, a market may potentially exist in a highly populated conurbation that covers several PCT boundaries. In such cases, joint commissioning for an identified service may be advisable. Indeed, many such arrangements have developed in the past in the North West.

Table Six. All (existing plus potential) providers for named markets

CLINICAL DESCRIPTION	MARKET	ALL EXISTING PROVIDERS IN PCT AREA	OTHER PROVIDERS WITHIN THE REGION
Infectious Diseases	Wellbeing & Prevention	2	
	Information & Advice	2	
	HIV & AIDS	2	4
	Counselling	1	
	Implant Provision & Fitting	1	
	Testing & Screening	2	
	Childhood Treatment	2	2
	Research	1	2
	Intervention & Treatment	1	10
	Vaccination	1	
Cancers & Tumours	Hereditary Cancer Assessment		
	Screening	1	0
	Cancer Nursing	3	7
	Palliative Care	3	3
	Diagnosis	1	1
	Cancer Neurology	0	1
	Childhood Cancer	0	3
	Rehabilitation	0	1
	Research & Development	0	1
	Chemotherapy	1	2
	Radiotherapy	0	1
	Surgery	1	1
Blood Disorders	Screening & Testing	2	8
	Intervention & Treatment	2	8
	Transplants	1	8
	Laboratory Services & Transfusion	1	8
....			
....			

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

PCT example, part five

Anytown PCT struggled slightly to sub-divide their Programme Budgeting categories into markets because this information had not previously been collected. However, robust estimates were made based upon local intelligence, with an intention of refining and expanding the quality and coverage of this information over the next six months. Notably, they had gaps in their data on alternative providers within the region. They planned to fill this gap in their knowledge over the coming months.

Market power

Once existing and potential providers have been identified, you may consider the issue of "market power" (that is, the ability of sellers to manipulate market price and volumes, as well as levels of quality and efficiency). Within economics, markets with one provider are called "monopolies"; two main providers are "duopolies"; and several powerful suppliers are "oligopolies". Whether a monopoly, duopoly or oligopoly exists often depends on how we define the geographic limits of a particular market. For instance, a local hospital may be said to be a monopoly as it is the only local acute provider. However, in the market for heart transplants, the unit may not have a monopoly if we take a national perspective. Therefore, determining the geographic spread of a market is essential in determining the potential existence of competition-inhibiting market power.

To determine the degree of market power in your local health markets, you should measure the percentage of spending allocated to the (one, two, three or more) main provider(s) versus all others, for each identified market. As Table Seven shows, if one or more providers capture a large percentage of local spending, then some degree of market power may exist. By calculating the percentage of spending captured by the main providers, your PCT may identify areas in which competition may be stimulated and health outcomes improved.

Table Seven. Spending with existing providers

CLINICAL DESCRIPTION	MARKET	SPENDING WITH PROVIDER ONE		SPENDING WITH PROVIDER TWO		SPENDING WITH PROVIDER THREE		ETC	
		£000s	%	£000s	%	£000s	%	£000s	%
Infectious Diseases	Wellbeing & Prevention	5	56%	4	44%				
	Information & Advice	5	56%	4	44%				
	HIV & AIDS	1,868	81%	187	8.1%	48	2.1%		
	Counselling	5	100%						
	Implant Provision & Fitting	5	100%						
	Testing & Screening	5	50%	5	50%				
	Childhood Treatment	30	75%	10	25%				
	Research	80	100%						
	Intervention & Treatment	734	33%	159	7%	72	3%		
	Vaccination	15	100%						
Cancers & Tumours	Hereditary Cancer Assessment & Screening	150	100%						
	Cancer Nursing	1,826	38%	1,573	32%	260	5%		
	Palliative Care	620	26%	540	22%	212	9%		
	Diagnosis	1,896	90%	217	10%				
	Cancer Neurology	10	100%						
	Childhood Cancer	281	78%	61	17%	18	5%		
	Rehabilitation	465	100%						
	Research & Development	220	100%						
	Chemotherapy	1,396	78%	218	12%	173	10%		
	Radiotherapy	465	100%						
	Treatment (All)	3,457	48%	868	12%	549	8%		
	Surgery	2,123	62%	1,322	38%				
....									
....									

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

Step Four. Analysing local market structures

Under WCC Competencies, all PCTs must stimulate their local health markets and have in place a range of responsive providers that they can choose from. As Diagram Two shows, Michael Porter developed a model of the "Five Forces That Shape Industry Competition" in order to help firms understand the nature and the degree of competitiveness in their markets. As shown, Porter argues that competition between existing competitors is not the only means of improving market competitiveness. In response, your PCT should examine all of Porter's five forces to help create what he calls "healthy market structures". To help you understand this approach, the Porter model is described in more depth below.

In the current context, Porter's model suggests that PCTs should focus on factors A to E in Diagram Two, which work together to promote healthy markets:

A. Potential entrants – how contestability affects competition

B. Rivalry amongst incumbents – how competition affects strategic behaviour

C. Strength of providers – how provider power affects transactions

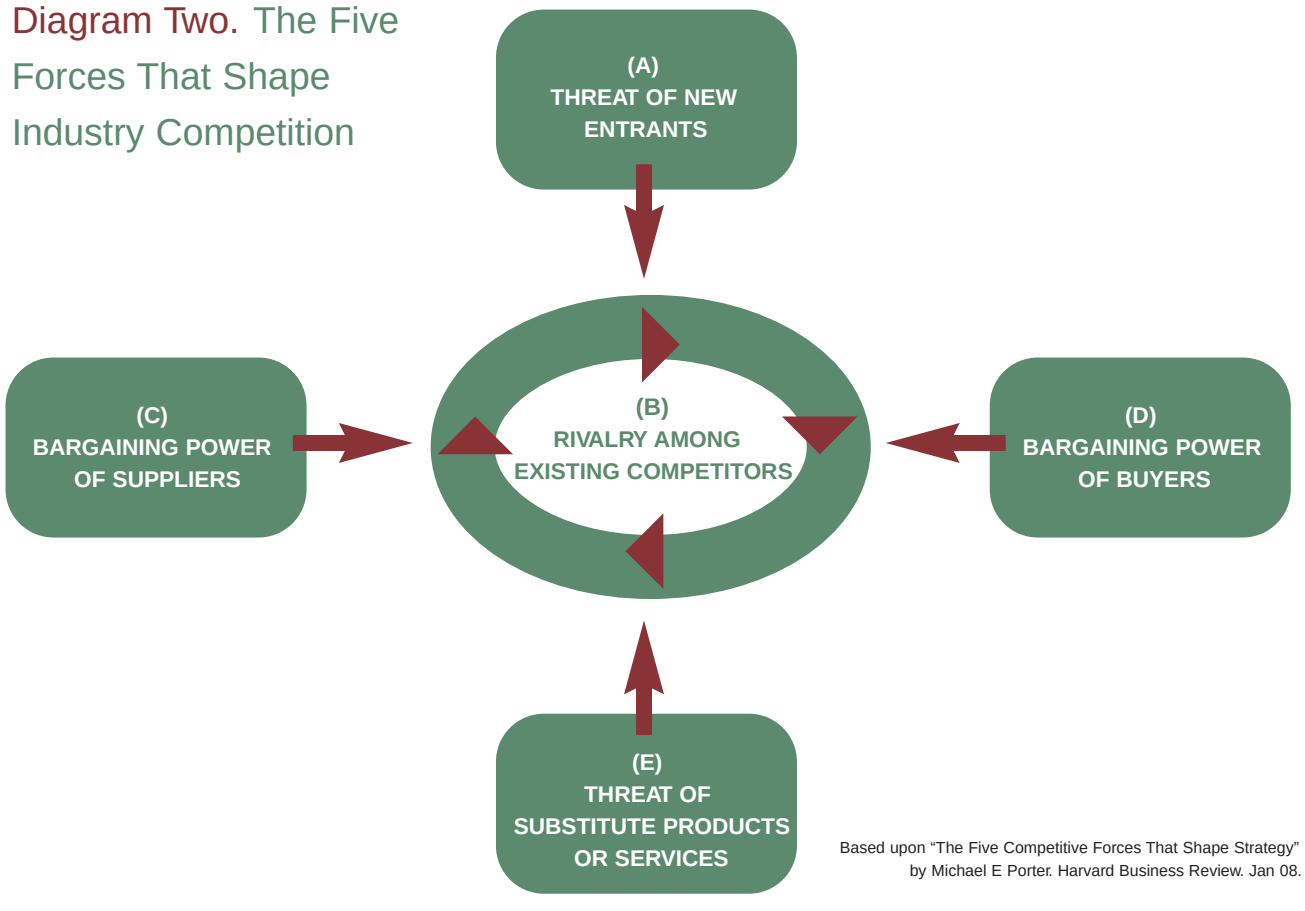
D. Strength of PCTs – how purchaser power affects transactions

E. Potential substitutes – how substitutability affects competition

These factors are important because unhealthy markets will not produce competitive outcomes. For instance, if you change a service because the existing monopoly provider offers low quality provision, then you may need a healthy market in order to improve the current outcome.

In order to perform a comprehensive HMA, your PCT should analyse all five forces, and record the proxies listed for their influence in Table Eight (overleaf). First, identifying potential entrants and stimulating their involvement in the market is one element in creating a healthy market structure. For instance, this may be achieved by reducing barriers to entry. Next, understanding the "rivalry" amongst existing providers is an important starting point for stimulating competition. For instance, your PCT should identify services that are switchable between local providers, which they do (or would be willing to) compete for. In response, gains may come from three main sources: (i) credible threats that make providers realise that they must improve performance in order to maintain contracts, (ii) rewarding the best with more work, and (iii) removing poor quality and/or inefficient providers.

Diagram Two. The Five Forces That Shape Industry Competition



Based upon "The Five Competitive Forces That Shape Strategy" by Michael E Porter. Harvard Business Review. Jan 08.

In Porter's model, Force C involves estimating the power of individual suppliers in each market by calculating the percentage of total spend they capture. In response, your PCT may wish to switch contracts in order to reduce the bargaining power of strong providers that ignore demands to improve quality and cost-effectiveness. In Table Eight, the bargaining power of suppliers is measured in terms of the proxy variable, capture of PCT spend.

In Table Eight, your bargaining power as a PCT is measured using the variable, provider's income from PCT. Obviously, in markets where you give providers 100 per cent of their income, you have greater bargaining power than those where you give, say, five per cent.

Finally in Porter's model, the existence of alternative products is seen as a means of promoting competition. This generates efficiencies because a desired set of benefits may be achieved via alternative means. For instance, face-to-face therapy may be a substitute for a prescribed antidepressant. Therefore, the PCT begins to contract for alternative counselling services as a switchable product.

To help your PCT gauge how patient outcomes may be improved through service innovations, the final column in Table Eight contains the variable, spend switchable to new products. This spend may consist of existing money only, new spending only, or a mixture of both.

Table Eight. All providers for named markets

CLINICAL DESCRIPTION	MARKET	EXISTING PROVIDERS	CAPTURE OF PCT SPEND		PROVIDER'S INCOME FROM PCT	POTENTIAL ENTRANTS (NAME)	SPEND SWITCHABLE TO NEW PRODUCTS	
			£000s	%	%		£000s	%
Infectious Diseases	Wellbeing & Prevention	Local Acute Provider	5	56%	22%		5	100%
		PCT Provider Arm	4	44%	98%		0	0%
						Third Sector Provider		
						Local Authority		
	Information & Advice	PCT Provider Arm	5	56%	98%		5	100%
		Local Acute Provider	4	44%	22%		4	100%
						Third Sector Provider		
						Independent Sector Provider		
	HIV & AIDS	Local Acute Provider	1,868	81%	22%		212	11%
		Regional Acute Provider 1	187	8.1%	2%		0	0%
		Regional Acute Provider 2	48	2.1%	1.4%		0	0%
		Regional Acute Provider 3	12	0.5%			0	0%
		PCT Provider Arm	8	0.3%	98%		6	75%
						GP Practice 4		
	Counselling	PCT Provider Arm	5	100%	98%		5	100%
						Third Sector Provider		
						Counsellor 4		
						Counsellor 12		
....								
....								

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

Table Eight populates Porter's model with existing data. As part of WCC Competency Seven, each PCT must provide projections of its future spending patterns. In response, Table Nine identifies market spending by existing and potential providers, with predictions made on how spending between the two groups is likely to change over the next five years. These data allow your PCT to examine rates of disinvestment and reinvestment in local markets, and show how quickly changes may happen.

Table Nine. Forecasting spending by existing and potential providers

MARKET	EXISTING PROVIDERS	POTENTIAL ENTRANTS	CURRENT MARKET SHARE	CURRENT MARKET SPEND	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
			%	£000s	£000s	£000s	£000s	£000s	£000s
Wellbeing & Prevention	Local Acute Provider		56%	5	4.1	3.5	3.1	2.7	2.5
	PCT Provider Arm		44%	4	4	4	4	4	4
		Third Sector Provider	0%		0.2	0.5	0.5	0.5	0.5
		Local Authority	0%		0.7	1.1	1.4	1.8	2
Information & Advice	PCT Provider Arm		56%	5	4.6	4.1	3.6	3.4	3.2
	Local Acute Provider		44%	4	3.2	3	2.9	2.3	2.1
		Third Sector Provider	0%		0.3	0.7	0.9	1.1	1.4
		Independent Sector Provider	0%		1	1.3	1.6	2.2	2.3
HIV & AIDS	Local Acute Provider		81%	1,868	1,764.2	1,700.5	1,658.1	1,594.4	1,530.7
	Regional Acute Provider 1		8.1%	187	187	187	187	187	187
	Regional Acute Provider 2		2.1%	48	48	48	48	48	48
	Regional Acute Provider 3		0.5%	12	12	12	12	12	12
	PCT Provider Arm		0.3%	8	4.2	4.2	4.2	4.2	4.2
		GP Practice 4	0%		107.6	171.3	213.7	277.4	341.1
Counselling	PCT Provider Arm		100%	5	4.2	3.8	3.4	3.2	2.8
		Third Sector Provider	0%		0.4	0.5	0.6	0.7	0.8
		Counsellor 4	0%		0.3	0.6	0.7	0.8	0.9
		Counsellor 12	0%		0.1	0.2	0.3	0.4	0.5
....									
....									

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

PCT example, part six

Anytown PCT are keen to expand the range of providers that they use not only to improve quality and efficiency, but to expand choice. To achieve these ends, new providers will be encouraged into the area, and a major shift in spending is envisaged between an existing provider with low quality and efficiency levels to a new, more promising unit.

Step Five. Identifying barriers to entry

As part of being successful World Class Commissioners, all PCTs should reduce or remove significant barriers to entry to local health markets. Barriers to entry are the advantages that incumbents have relative to new entrants. Porter argues that such barriers derive from seven major sources:

Supply-side economies of scale: When firms that produce at larger volumes enjoy lower costs per unit, which new entrants could not replicate because they lack the trading volumes

Demand-side benefits of scale: When the price users are willing to pay increases with the number of other buyers, for instance, other users on a network such as mobile phones

Customer switching costs: The costs consumers bear when switching suppliers, for instance, the time taken in moving computer files from one computer operating system to another.

Capital requirements: The need to invest large financial resources may deter new entrants

Incumbency advantages independent of size: Simply by being in the market already incumbents have advantages such as preferential access to raw materials

Unequal access to distribution channels: In order to supply their goods new entrants may need to secure access to distribution channels, for instance, sellers of new ice creams have to gain fridge space in units owned by their rivals

Restrictive government policy: For instance, government policy may help public sector providers in many different ways, from capital investment to commercial guidance, which private providers cannot access

In order to enter your local markets, new entrants may have to overcome some or all of the barriers listed above. Therefore, your PCT should examine which of your markets exhibit signs of significant barriers to entry, and details of them should be listed and described in Table Ten. Unless these barriers are appropriately addressed, your PCT may be unable to promote healthy local markets and meet all of its WCC competencies. However, barriers to entry exist in most forms of markets and it is unlikely you will be able to remove all of the barriers you will identify.

Table Ten. Barriers to entry in local markets

MARKET(S)	SUPPLY-SIDE ECONOMIES OF SCALE	DEMAND-SIDE BENEFITS OF SCALE	CUSTOMER SWITCHING COSTS	CAPITAL REQUIREMENTS	INCUMBENCY ADVANTAGES INDEPENDENT OF SIZE	UNEQUAL ACCESS TO DISTRIBUTION CHANNELS	RESTRICTIVE GOVERNMENT POLICY
Wellbeing & Prevention	No barrier	No barrier	No barrier	No barrier	No barrier	No barrier	No barrier
Information & Advice	No barrier	No barrier	No barrier	No barrier	No barrier	No barrier	No barrier
HIV & AIDS	Cheaper per head to treat more patients than less	No barrier	Difficulties in accessing patient records	Need secondary care-based facilities	Incumbents have advantages of being known and trusted by patients	Incumbents have existing relationships with suppliers	Government issues NHS policy recommendations not yet followed in private sector
Counselling	No barrier	No barrier	Wider choice may lead to more widespread locations and increased travelling costs for patients	No barrier	No barrier	No barrier	No barrier
Implant Provision & Fitting	No barrier	No barrier	No barrier	Set-up costs may be prohibitive	No barrier	No barrier	Government issues NHS recommendations not yet followed in private sector
Testing & Screening	Cheaper per head to treat	Patients may wish to have testing, screening & treatment in one location	No barrier	Set-up costs high as new entrants will have to invest in equipment and staff	GPs more likely to refer to existing providers	No barrier	Certificates of registration required
....							
....							

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

Step Six. Pulling your information together

HMA is a guide to decision-making, and should be built into the mainstream commissioning process for your PCT. Table Eleven pulls together some data collected earlier in this guide and lists which clinical areas should be considered for alternative provision, on quality and efficiency grounds. Within these areas are the markets you identified in Table Eight, which will have existing and potential providers. You can now assess: (i) which services need to change because of low quality and/or inefficient provision, and (ii) which potential providers have high enough quality and/or productivity levels to be replacement or complementary suppliers. By including information from Tables Two, Five and Eight, you will find that Table Eleven now provides an important summary of existing and potential performance in your main Programme Budgeting categories.

Although Table Eleven is informative, unless your local markets are healthy, switching providers may not produce the desired results. Therefore, it is recommended that your PCT assesses (and, where possible, improves) market health before using HMA recommendations in an attempt to improve the quality and the efficiency of commissioned services. In response, Table Twelve details base-line intelligence based upon Porter's five forces, which are designed to define and to measure market health.

Overleaf, Table Twelve records the potential for expansion in provider numbers achievable by your PCT. WCC sub-competency 7c requires PCTs to identify existing and potential providers at a disease level, with the objective of assessing ways in which treatment options can be extended. By identifying potential providers your PCT can begin the process of analysing how choice may be improved.

Table Eleven. Priority markets for change and quality of providers

CLINICAL DESCRIPTION	CLINICAL AREAS THAT MAY REQUIRE ALTERNATIVE PROVISION OR EXPLORATION (FROM TABLE FIVE)	MARKET(S)	EXISTING PROVIDERS (FROM TABLE EIGHT)	LEVEL OF QUALITY AND EFFICIENCY FOR EXISTING PROVIDERS (FROM TABLE TWO)	POTENTIAL ENTRANTS (FROM TABLE EIGHT)	LEVEL OF QUALITY AND EFFICIENCY FOR POTENTIAL PROVIDERS (FROM TABLE TWO)
Infectious Diseases	Change	Wellbeing & Prevention	Local Acute Provider	Low		
					Third Sector Provider	High
					Local Authority	High
	Change	Information & Advice	PCT Provider Arm	Low		
			Local Acute Provider	Low		
					Third Sector Provider	High
					Independent Sector Provider	Medium
	Change	HIV & AIDS	Local Acute Provider	Low		
			PCT Provider Arm	Low		
					GP Practice 4	High
	Change	Counselling	PCT Provider Arm	Low		
					Third Sector Provider	High
					Counsellor 4	To be determined
					Counsellor 12	To be determined
	Change	Implant Provision & Fitting	PCT Provider Arm	Low		
					GP Practice 11	High
....						
....						

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

Table Twelve should be constructed using data from Table Eight, but only including markets deemed to include low quality and inefficient provision identified in Table Eleven. This abridged table contains proxies for Porter's five forces, which can inform PCT discussions around the health of local markets. For example, Anytown PCT decided to stimulate the health of its local market for HIV and AIDS services after performing its HMA. Table Twelve therefore suggests that the PCT could improve quality and efficiency levels by encouraging new entrants and stimulating "rivalry". Indeed, as a rule of thumb: healthy markets are more likely to improve quality; less healthy markets may not deliver better patient outcomes. Therefore, it is recommended that your PCT assess (and, where possible, improve) market health before using this commissioning route to improve the quality of NHS services.

Table Twelve. Market structure using Porter's five forces

MARKET(S)	EXISTING PROVIDERS (NAME)	CAPTURE OF MARKET SPEND		SUPPLIER INCOME FROM PCT	SPEND SWITCHABLE TO NEW PRODUCTS		POTENTIAL ENTRANTS (NAME)
		£000s	%	%	£000s	%	
Wellbeing & Prevention	Local Acute Provider	5	56	22	5	100	Third Sector Provider Local Authority
Information & Advice	PCT Provider Arm Local Acute Provider	5 4	56 44	98 22	5 4	100 100	Third Sector Provider Independent Sector Provider
HIV & AIDS	Local Acute Provider PCT Provider Arm	1,868 8	81 0.3	22 98	212 6	11 75	GP Practice 4
Counselling	PCT Provider Arm	5	100	98	5	100	Third Sector Provider Counsellor 4 Counsellor 12
....							
....							

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

PCT example, part seven

Anytown PCT found the process of pulling its HMA data together useful. For instance, the information in Table 11 was seen as a helpful means of deciding which markets to enter; whilst Table 12 outlines which of these are healthy. Using this intelligence, the PCT procurement panel decided to go to tender for HIV & AIDS services. As part of this process, the PCT redesigned its care pathways for these services and made capacity available to community providers in the local secondary care trust (thus removing the barrier to entry "need secondary care-based facilities" mentioned in Table Ten). The PCT also began to systematically work through all markets prioritised for change by its HMA, with the intention of exploring new providers and improving market health.

Step Seven. Stimulating healthy markets

Now you have identified the markets that your PCT may wish to enter, Step Seven extends the analysis presented in Table Twelve to directly address the issues of market power and barriers to entry. As previously discussed in Step Three, the ability of providers to manipulate market prices and volumes (that is, their market power) is likely to affect the quality and efficiency of commissioned services. Similarly, advantages enjoyed by providers (that is, the barriers to entry), which were discussed in Step Five, may discourage new entrants from entering your local health markets. Consequently, managing market power and barriers to entry is an important task for PCTs wishing to create healthy markets for local services.

To determine the degree of market power in your local health markets, you should measure the percentage of spending allocated to the (one, two, three or more) main provider(s) versus all others, for each identified market. As Table Thirteen shows, if one or more provider(s) capture a large percentage of local spending, then some degree of market power may exist. By calculating the percentage of spending captured by the main providers, your PCT may identify areas in which competition may be stimulated and health outcomes improved. This information may then be incorporated into a local strategy for promoting market health.

Finally, by summarising comments from Table Ten in the last column of Table Thirteen you may identify the main barriers to entry for your target markets. In theory, markets with high barriers to entry (such as high capital costs) are more likely to have high degrees of market power (such as a monopoly provider) because competitors are effectively excluded from competing. Therefore, spending levels and barriers to entry should be interpreted together to ascertain whether local market structures promote or inhibit competition. Armed with this information, your PCT may now take steps to further stimulate market health.

Table Thirteen. Market power and barriers to entry

MARKET(S)	SPENDING WITH PROVIDER ONE		SPENDING WITH PROVIDER TWO		SPENDING WITH PROVIDER THREE		SPENDING WITH OTHER PROVIDERS		BARRIERS TO ENTRY
	£000s	%	£000s	%	£000s	%	£000s	%	
Wellbeing & Prevention	5	56	4	44					No barriers
Information & Advice	5	56	4	44					No barriers
HIV & AIDS	1,868	81	187	8.1	48	2.1	203	8.8	Cheaper per head to treat more patients than less Difficulties in accessing patient records Need secondary care-based facilities Incumbents have advantages of being known and trusted by patients Incumbents have existing relationships with suppliers Government issues NHS policy recommendations not yet followed in private sector
....									
....									

Note: The data in this table relate to the hypothetical example of Anytown PCT. You will add your own PCT data when completing this table.

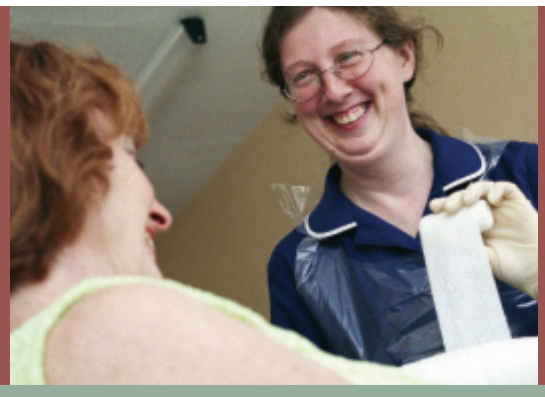
Conclusions

The aim of HMA is to identify commissioning priorities for the use of market levers and incentives to drive up the quality and efficiency of where it is needed most. However, for this approach to work in practice, your PCT must:

1. Identify markets that can deliver improved quality and efficiency
2. Stimulate market health to ensure that better outcomes can be secured
3. Set local commissioning priorities for using these markets

By assessing which markets have the potential to deliver improved quality and productivity, the data presented in this HMA guide allow your PCT to set local priorities for exploring the benefits of using alternative providers. However, as Porter's five forces make clear, these markets may fail to deliver their expected outcomes unless unhealthy features such as market power and barriers to entry have been removed.

As part of WCC Competency Seven your PCT should understand its markets, stimulate their health and act to reduce any barriers to entry. This guide works to deliver these key themes of WCC by providing the baseline assessments required to perform a full-scale market analysis. By following the Seven Steps listed here you should be able to deliver many of the WCC sub-competencies listed in Table One. However, many of the tasks require strategic planning and commissioning outside the scope of this guide. Therefore, it should be remembered that market analysis is simply a tool for promoting better service delivery as part of the overall commissioning process. Indeed, HMA is only the beginning of the journey and not the destination.



PCT example, part eight

Anytown PCT found the process of HMA extremely useful. Firstly, using the NHS North West guide improved their ability to deliver WCC Competency Seven by organising their overall approach to health markets and their stimulation. Next, following this guide helped the commissioning process by drawing together existing and new sources of data in a way that threw new light on local services. In particular, the PCT found the process of identifying new providers and testing the health of local markets extremely useful. Finally, the PCT found that the HMA process helped them in contract negotiations with low quality and/or inefficient providers because they now had an alternative means of delivering high quality, cost-effective care. In sum, Anytown felt their HMA process an all-round success.

7 Steps to Health Market Analysis

NHS North West